WORKING TOGETHER IN THE HEALING MINISTRY

A REPORT OF THE CONSULTATION OF NATIONAL/ REGIONAL CHRISTIAN COORDINATING AGENCIES/ DESK FOR HEALTH

NEW DELHI 7-11 September, 1991

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WORKING TOGETHER IN THE HEALING MINISTRY

A Consultation of National/Regional Christian Coordinating Agencies/Desk for Health

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BACKGROUND

In 1985 the African Christian coordinating agencies working in the area of health met in Ghana and agreed to meet regularly thereafter. In November 1989, the Christian Conference of Asia (CCA) called a health consultation in Bangkok, and here again a desire was expressed for greater exchange and dialogue among Christian health and medical programmes in countries in the South. The Christian Medical Commission of the World Council of Churches, in collaboration with the Christian Medical Association of India (CMAI), therefore called and sponsored this international consultation to provide an opportunity to learn from each other through the sharing of experiences and to create a mechanism for ongoing collaboration.

PARTICIPATION

The aim of the consultation was to bring together individuals responsible for the coordinating of church related/based health and medical activities in Asia, Pacific, Africa, Latin America and the Caribbean. The list of participants is given in Appendix I. Breakdown of participations was as follows:

Sl. No.	*Region/Agency*	*Invited*	*Participated*
1.	Africa	17	13
2.	Asia/Pacific	9	5
3.	Latin America/Caribbean	3	2
4.	CMC/WCC	2	2
5.	CCA	1	1
6.	AACC	1	—
7.	Resource Persons	1	1
8.	Others (all from Asia)	1	4
	Total	35	28

SETTING THE AGENDA

The final programme is given in Appendix II. The process of getting to know one another, sharing expectations, questions and concerns and finalizing the agenda of the consultation started, informally, on 7th September. Thus, the participants were able to add to and update the

expectations, as previously stated in their responses to a questionnaire sent out before the consultation. Participants were interested primarily in the following areas:

a) financial stability and sustainability of church-based health and medical activities;
b) ways to equip people for their tasks in health and healing activities;
c) the role of the Church in health and healing and what it involves;
d) a time of fellowship for personal and spiritual growth;
e) sharing of experience, making friends and continuing the dialogue;
f) establishing a network or mechanism for follow-up, and continuing collaboration;
g) improving relationships.

CONSULTATION STATEMENT

We, the Representatives of Coordinating Agencies, National and Regional Health Desks from 22 countries in different regions (Africa, Asia, Pacific, Latin America and the Carribean) met in New Delhi, 8 - 11 September 1991.

We reflected on the difficulties, challenges and successes we have experienced in our work. We identified critical problems in the areas of:

1) *Justification and uniqueness of the Christian ministry of healing;*
2) *Relationships between coordinating agencies, donors, churches, member institutions and government;*
3) *Human resource development;*
4) *Financing and sustainability.*
5) *Cooperation/networking and solidarity between coordinating agencies and churches in the South involved in the Healing Ministry.*

From this process we affirm the Church's healing ministry and the need to assist the Church to fully recognize its role therein. We recommend the following:

1. ***A rediscovery of the healing ministry of the Church by***

   a) *defining the healing ministry and developing policy statements;*

   b) *developing healing liturgy services and prayers as part of regular worship;*

   c) *organising workshops, seminars, retreats to create awareness and develop skills;*

   d) *developing "base" healing communities;*

   e) *promoting/enhancing the curricula of health and theological training schools/programmes.*

2. ***Human resource development***

   Commitment to the development of people through:

   a) *improving current conditions of service;*

   b) *adopting staff development plans;*

   c) *undertaking appropriate training and capacity building activities;*

   d) *establishing exchange programmes within and between countries and on the international level;*

   e) *adopting alternative models of training to empower all persons for participation;*

   f) *facilitating the development of spiritual leadership, guidance and nurturing through constant spiritual renewal, i.e. Bible studies, devotions, retreats.*

3. ***Networking and Sharing of Information***

   a) *through regular meetings and contacts at regional, sub-regional and international levels, including exposure visits to enhance South to South solidarity;*

   b) *sharing of information through bulletins, newsletters, reports and other publications;*

   c) *encouraging the establishment of health desks by National Ecumenical Councils and Regional Ecumenical Councils;*

   d) *enhancing North-South sharing towards building partnership and two-way learning.*

4. *Promoting sustainability at all levels through*

a) developing effective and efficient management systems;
b) developing income generating programmes;
c) developing a common fund at the international level, to be supported primarily by countries from the South, for financing joint activities, to be administered by CMC.
d) organising special seminars and workshops at various levels.

In all this ***CMC is requested to facilitate the following,*** *within available resources:*

a) the creation of new coordinating agencies;
b) exchange programmes;
c) regular meetings at all levels;
d) exchange of information;
e) strengthening of the Church in its healing ministry;

while we the participants commit ourselves to:

a) keep in touch with each other;
b) share information, for example through bulletins, with CMC and with each other;
c) help to provide care and support for exchange persons we receive in our country;
d) help raise support for the programmes we have discussed here;
e) pray for each other.

THE PROCESS

After one whole day of informal sharing and getting to know one another, the participants elected three people to join with the one representative from CMAI and from CMC to form a **steering committee.** This committee was charged with the responsibility of ensuring that the participants' expectations were met by the end of the consultation. Two other participants, one from CMAI and one from CMC, were responsible for recording the proceedings.

The official consultation started with the opening worship, led by Rev. Chacko of CMAI. Each day of the consultation began with a worship session led by participants.

Time was allowed for biblical, theological reflection on the subject of health and healing. These sessions were led by the Rev. A.C. Oommen, a CMAI resource person. He based the studies on expectations, experience and expression of the healing ministry. A summary of the Bible studies is given in Appendix III. These inspiring sessions provided the biblical framework for discussing the churches' ministry of healing. Through the daily worship, devotions, and informal sharing, the group of delegates, who were previously strangers to each other and coming from different continents, cultures and backgrounds, soon became a community. Their common commitment was to learn together ways by which they could become more effective facilitators in the healing ministry of the Church.

1. Why the Consultation - CMC's Expectation

The first formal consultation day started with a presentation from the director of CMC, Dr. Dan Kaseje.

The expectations of CMC were consistent with those of the participants. In his opening address, Dr. Dan Kaseje explained that the meeting was crucial because church related health and medical services were going through major crises in many countries. Many governments were finding it impossible to continue supporting church-based services. Even in countries where governments had taken over church-based health institutions, they were handing them back to the churches with the result that whole systems of health care on which millions of people depended were collapsing. This situation has been aggravated by a prevailing donor "fatigue" coupled with shifting global priorities to new challenges. It was therefore important to come together to share strengths and weaknesses, problems and solutions, innovations and opportunities and thus generate some common approaches and strategies that could enable the churches to continue in this vital mission. It is always encouraging to know that one is not alone in problems and crises and that being able to come together and share experiences provides hope to cope with the problems.

Dr Kaseje challenged the participants to renew their vision for the churches' role in health and healing, a vision that recognizes healing as much more than medical cure and actually more clearly related to **care** and **wholeness.** Once this vision is clear then churches can become more involved in charting the way towards their active involvement so that health and healing are no longer optional "extras" but at the core of the ministry of the Church. In this, the agencies need one another; hence the

need for a mechanism for ongoing networking, exchange, and solidarity as we choose together to minister to the majority at the fringes of our societies - the poor and marginalized.

Questions have been asked about what technology is appropriate for the churches' health services. Should the Church strive to keep up with medical advances, availing themselves of the most modern medical equipment on the market? Where should the Church place the emphasis in distributing its resources: hospitals or community-based health care?

Dr Kaseje suggested that the answers to these questions cannot come from outside the situation in which they are being asked. Futhermore, the answers will depend on asking other questions:

— What are the priority health problems? What are their root causes and hence how best can they be dealt with?

— What, therefore, is the vision of the Church? What policies or principles govern the churches' involvement in health care and healing activities so that health care is relevant to the local priorities and the local social, cultural and economic context?

We have to make choices in our real world, and our choices are necessarily linked to key problems, priorities, policies and resources available. These then, should dictate the choice of technology appropriate and necessary for the mission of the Church to promote or restore health, healing and wholeness. The overriding vision in our deliberate choice to work for the poor is that all the people of God deserve equal access to health care and healing resources. Health thus becomes a justice issue. The Church is a vital source of healing and must provide care equitably, efficiently, and effectively, using available resources and in a manner that can be sustained indefinitely.

Dr. Kaseje concluded his address by clarifying the role of CMC/ WCC - to facilitate coordination of health and healing activities; to document, share and popularise innovations; to promote human resource development; and to confront issues and structures of injustice in health care activities.

The rest of the first day was devoted to identifying common problems, analysing their root causes and agreeing on the priority problems that would be further explored in a search for solutions and recommendations for action. The problem identification process was introduced by two case studies: one from CMAI and the other from the Christian Health

Association of Sierra Leone (CHASL). The case studies, summarized below, provided examples of coordinating agencies in India and Sierra Leone, highlighting the problems they face and how they have coped.

2. Case Studies

(i) CMAI

The work of CMAI was presented by Dr. Sukant Singh (see also Appendix IV). The problems faced by the agency included lack of mission, poor management, inadequate personnel, and insufficient resources - especially financial. He shared some approaches adopted by CMAI to help address this situation but explained the limitations they had encountered. Participants then raised questions in regard to health problems in India, the relationships of CMAI to the government, the churches, the Roman Catholic Church, and others. Many asked how CMAI had been established, how it was financed and how it worked with its members. Dr. Daleep S. Mukarji confirmed some of CMAI's difficulties mentioned above. He helped to answer some of the questions and shared CMAI's strategy to assist the churches in their ministry. CMAI had plans for improving its financial stability and the nurturing of its staff. CMAI generated income from members, training programmes, consultancy and advisory services, publications, endowments and support from regular donors.

(ii) CHASL

Mrs. Marion Morgan, executive director of CHASL, shared information about her country, the history and work of CHASL and some of the problems CHASL has encountered in working with the government and the churches. She gave details on how CHASL raised funds through income from members (13%), charges for services (30%), donations (10%) and institutional fees (20%). During the discussion that followed the question was raised as to whether coordinating agencies should exercise control, power and authority over member institutions. The question was also raised whether the agencies should become directy involved in health care (CHASL had started a PHC programme of its own).

3. Group Discussions

Following the presentation of the case studies participants divided into four groups to discuss the case studies, with particular regard to the problems presented, their similarity to those encountered by other

agencies represented, and other problems experienced but not mentioned in the case studies.

Two questions were used to guide group discussions:

— What are the main issues, problems, or constraints involved in Christian medical and health care activities at this time?

— What are the main problems experienced by the coordinating agencies or health desks of ecumenical bodies?

Problems and Issues relating to christian medical institutions and health programmes identified by the groups, fall under the following headings:

A. SUSTAINABILITY AND SELF-RELIANCE

It was pointed out that most of the institutions and programmes had been inherited from the missionary churches and agencies with missionary activities. The local church had neither been adequately prepared for taking them over with the same vision and sense of mission, nor did it have the capacity to manage and sustain them. This has meant that many countries still depend on expatriate personnel which is only a temporary solution, particularly in the volatile political climates of these countries. Some countries now refuse to grant work permits to church-related expatriates.

There appeared to be a lack of understanding within local churches as to their role in health care and healing. Instead of supporting the health institutions and programmes, the churches and local congregations often look to them for personal gain, i.e. employment or preferential treatment for some church members, church leaders, their relatives and friends. For this reason, amongst others, the institutions and programmes experience financial constraints that render them either dependent on donors (and thus subject to their influence), or force them to become commercialized and secularised in order to survive. Many such institutions offer poor quality care and are often driven towards medical technology that is inappropriate to local needs, beyond the economic capacity of the people served, and beyond the available resources to maintain. Thus, the institutions become vulnerable to internal politics and manipulation, and targets for donations of inappropriate drugs and supplies, which only increases their burden.

These problems are aggravated by the lack of a core of committed Christian professionals with a vision and calling for long term involvement in the churches' health and healing ministry. Within the churches

themselves there also seems to be a lack of committed people; people that could play the facilitating role in the healing ministry and thus enable the creation of a sharing and giving community with a wholistic view of health, in which every person has a definite role and responsibility.

B. MANAGEMENT

The problems mentioned above lead to absence of clearly stated policies governing the churches' involvement in health and healing and detailing the principles and ethics of practice. The personnel of such programmes tend to be short-term, and hence inexperienced, as the result of the poor terms and conditions of service offered to them and the absence of a secure career structure.
There is no mechanism available for inter-institutional sharing of experiences, resources, innovations, and mutual support.

Problems and issues relating to coordinating agencies:

The groups articulated problems in the following areas:

A. SUSTAINABILITY AND SELF-RELIANCE

Financial constraints were mentioned by all the groups. Problems in obtaining financing render the agencies not only dependent on external donors but also susceptible to their influence and control. Some agencies have found themselves developing donor driven programmes that are of questionable relevance and appropriateness to the local context.

Poor terms and conditions of service frequently lead to loss of competent staff. There is also a shortage of personnel having a vision and mission in the healing ministry of the Church.

B. RELATIONSHIPS, SHARING AND COMMUNICATION

Most of the problems of the coordinating agencies and health desks mentioned by the groups in relation to information sharing and coordinating fell into the following categories:

— Poor communications and information sharing among membership/church/other coordinating agencies;
— Lack of support from the churches and lack of commitment from church leaders to the work of the agency;

- Denominational and theological differences that negatively influence the accomplishment of Christian medical and health activities;
- Lack of executive authority over the member institutions;
- Mistrust and misunderstanding among churches of the role of the coordinating agency;
- Power struggles, mistrust, and other problems in interpersonal relationships between the partners involved with the coordinating agency and sometimes in the agency itself.

Many groups also spoke of poor relationships with and lack of support from not only the government, but also from the Church. Member churches, donors, and other agencies often bypass the coordinating agency in dealing with member institutions, thus undermining the credibility, confidence, and legitimacy of the coordinating agency.

Among the partners involved, roles, responsibilities and expectations remain unclear. Perspectives, principles and priorities may often differ from those of the coordinating agency.

Many coordinating agencies are not directly related to the churches, resulting in a lack of accountability and responsibility to the churches on the part of the coordinating agency and a lack of cooperation and commitment to the coordinating agency on the part of the churches.

There is inadequate information sharing at country, regional, and global levels. In some cases, such inadequate sharing may actually be a deliberate lack of transparency, which indicates an unhealthy competition at the different levels among institutions, agencies, denominations and other religious bodies.

Day 2 of the consultation was devoted to seeking solutions to the problems identified on day 1. To do this the groups first had to agree on priorities among the problems before listing suggestions for appropriate solutions and responses.

Priority issues from group work

The following issues that emerged from group work were identified as high priority and were then further discussed to determine possible solutions and/or follow-up mechanisms:

- The need to clarify the role of the Church in health and healing. The group wished to explore further the uniqueness of Christian health care activities.
- The need to strengthen relationships among the churches, the coordinating agencies, member institutions, governments, donors, and other NGOs. The group wished to explore mechanisms for sharing, collaborating, and communicating effectively to this end.
- The need to emphasize human resource development through identifying, training and "mentoring" Christian health workers who show capacity to become committed and effective managers of Church institutions at all levels. The group wished to examine further the ways in which they could develop committed personnel, church leaders, and congregations for the health and healing ministry.
- The need for mechanisms to promote sharing, communication, and mutual support, e.g. through inter-agency exchange visits, short courses and internships. The group wished to consider ways to provide mutual support in human resource development and the sharing of resources in this important endeavour.
- The need to improve terms and conditions of service and to evolve working situations that provide job satisfaction. The group wished to discuss further how they could retain competent and qualified staff for the healing ministry of the Church.

Possible solutions and actions

New working groups were then formed to further explore the above priority issues and make recommendations for action. The groups spent most of the day in discussion. At the end of the day the groups realized that there were many problems that were "solution resistant". They underscored the importance of prayer and the need to dependend on God and His resources.

The groups presented their plans in a plenary session at the end of the day, but there was no time for plenary discussion.

4. Plenary presentation/discussion on suggestions and recommendations

Day 3 day started with plenary discussion of the suggestions and recommendations from the groups. The outcome of these discussions is presented below under the following sub-headings:

A. THE ROLE OF THE CHURCH IN HEALTH AND HEALING

The group agreed that the Church's healing ministry is unique in that it is Bible-based and in keeping with the mandate of the Church, to preach, teach and heal. Healing and wholeness are integral to salvation for all mankind.
There is a wholistic relationship between body, mind, and soul, and the healing practice must take this into consideration. Healing has to be comprehensive and integrated, involving the physical, mental, social, spiritual, economic and political wellbeing of individuals and communities. Some individuals have special gifts and training in this ministry which should be used to give God the glory and build his kingdom, by witnessing to the love of Christ- through a compassionate, considerate, caring, and a committed approach.

The healing ministry must offer hope and enable people to face suffering, pain, and death. The involvement of the Church in health care for the weak and oppressed gives expression and purpose to the Church's commitment to the ministry of healing. It was concluded that the Church has a unique role in the ministry of healing and wholeness to the poor and must be fully involved.

Equiping and strengthening the Church in the healing ministry should start by effectively sharing the above vision and mission of the Church, with all the people of God, so as to enable them to participate fully as informed and competent partners in the mission. It was suggested that this be done by:

a) Building commitment within the Church to the healing ministry through Bible studies, workshops, seminars and retreats focusing on specialized groups of the Church — youth, women, health professionals, clergy, and lay leadership. Theological and health professionals should be targeted when they are still undergoing training to help them discover and commit themselves to the healing ministry of the Church. This process can be strengthened by providing role models for young people that will inspire and challenge them to pursue a lifetime vocation in the healing ministry.

b) Sensitizing the Church to its responsibility in health and healing and strengthening its capacity to undertake the task. Churches and health institutions should be jointly involved in identifying

the needs of the people they serve in order to work together in an active and participatory process of building healing communities.

B. RELATIONSHIPS, SHARING, COMMUNICATION AND NETWORKING

a) The institutional management boards should be expanded to include suitable individuals from within the Church but also from outside local congregational and/or church boundaries. The boards of the coordinating agencies should also consist of people with a variety of competencies, skills, and gifts, who are able to represent specific constituencies, including member institutions, and also to facilitate regular contact between churches, member institutions and coordinating agency leaderships.

b) Coordinating agencies should avoid assuming direct executive control, ownership, or authority over member institutions. Rather, they should seek authority based on sound principles, values, and policies and through the development and maintenance of good relations with churches, donors and government.

c) Coordinating agencies should be more specific in defining their roles and responsibilities, in consultation with their partners. Such roles could include representing church and member interests to governments and donors; screening projects for funding; channelling funds and resources; providing services; undertaking training; establishing ethical and quality standards; and facilitating good management, the creation and implemention of service policies, and human resource development.

d) Within the structure of coordinating agencies, space should be provided for church leaders.

e) The coordinating agency should possess adequate staff, infrastructure, resources, and capacity to respond to the needs of its members.

f) Mechanisms for information sharing and greater networking should be established, e.g. regular meetings at various levels and the sharing of information, experiences, and innovations through newsletters, annual reports and other publications. A directory of coordinating agencies should be developed and circulated by CMC. The directory should indicate, as far as possible, resources

available within each agency from which others could benefit. CMC should also provide space in its bi-monthly publication Contact for regular sharing of news, views and experiences.

C. SUSTAINABILITY AND SELF-RELIANCE

The groups recommended several possible actions in this area for both coordinating agencies and their member institutions:

a) Hold special workshops, conferences, and seminars on sustainability and financial viability;

b) Invest in endowments and real estate or building projects;

c) Charge for services and administrative support and introduce other innovative income generation schemes.

d) Organize innovative fund-raising activities (e.g.medical insurance programmes and pot-luck meals) and ensure good financial management and stewardship. Users of services should be helped to realize that health care costs money and must be paid for. Patients who can pay for luxury care should be charged accordingly to help cover the costs of those unable to pay for basic health care.

e) Determine limits of expansion of services. Use of alternative and indigenous systems of medicine should be encouraged when and as appropriate. Appropriate technology to meet the most common health needs should be made available. Train and deploy less expensive allied health professionals.

f) Influence government policies to provide greater support to health-related NGOs.

g) Provide for stable staff and management so as to promote financial stability.

h) Seek loan schemes when productive investments are possible.

i) Improve monitoring and review/evaluate coordinating agencies to enable them to develop clear goals and strategies for financial stability.

D.HUMAN RESOURCE DEVELOPMENT

Human resource development was seen as an urgent priority for the churches' health and healing minstry. The following actions were suggested:

a) Share information on training programmes and develop specific innovative and alternative training courses as necessary.

b) Identify suitable candidates in the healing ministry and arrange training for them. This may mean providing increased funds for training, continuing education, exchange visits, study tours, and scholarships. Management skills should be included in training for senior staff. This should be coupled with efforts to improve the working conditions, security, job satisfaction, and fringe benefits for staff and to provide an attractive career structure.

c) Identify young people in schools and colleges who could be motivated to pursue a vocation in the healing ministry and enable them to become effective leaders and care providers in the Church.

d) Share staff between member institutions thus providing mutual support. This may also benefit individual members of staff. This should include exchange visits mainly among countries from the South.

e) Play a catalytic role in human resource development especially within the churches and their hospitals. Seek leadership for hospitals in the immediate future.

f) Organize periodic workshops, seminars, consultations and informal contacts at the national, regional, and global levels, to focus on common issues and problems, e.g. financial sustainability of institutions, programmes and agencies.

g) Train health professionals, especially nurses, on various aspects of healing and caring, in order to have a "chaplaincy service" in every institution that is not necessarily dependent on professional chaplains.

h) Train and develop human resources with emphasis on preparing leaders, while using the present available leadership wisely.

Experience has shown that training need not be formal. Improved communication, educational material, and a variety of channels for education can be used for this purpose.

Resources - financial, human, and institutional - should be pooled to enable the implementation of the above recommendations. Resource sharing should be coordinated by CMC/WCC which would also provide leadership and facilitation in the implementation process. This process would be enhanced by the formation of health desks in the regional ecumenical bodies, such as the AACC and the CCA.

CONCLUSION

As the consultation came to an end, many participants expressed their thanks for the opportunity to share, the hospitality extended by CMAI, the organization of the meeting, and the fellowship they had experienced. Most participants felt they had gained personally and professionally. Most asked for a follow-up consultation in three years, so as to review progress and activities at regional and national levels. On behalf of CMC, Dr. Dan Kaseje reminded participants that CMC was keen to facilitate follow-up and hoped for greater cooperation and sharing in this process. Participants shared their support and expectations of CMC and assured Dr. Kaseje of their willingness to work together.

The meeting closed with prayers.

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PROGRAMME

1. Saturday, 7 September 1991

10.00 am to 4.30 pm	-	Planning and preparatory meeting at YMCA All participants invited
7.30 pm	-	Dinner at Dr. Mukarji's residence

2. Sunday, 8 September 1991

9.00 am	-	Worship - CNI Free Church, Parliament Street
10.00 am	-	Informal meeting (YMCA)
1.00 pm	-	Lunch
2-5 pm	-	Informal meeting continues
6.00 pm	-	Opening worship
7.00 pm	-	Dinner
8.00 pm	-	Departure by bus for Sound & Light Programme

3. Monday, 9 September 1991

7.30 am	-	Breakfast at YMCA/YWCA
8.15 am	-	Departure for CMAI
9.00 am	-	Devotions I
9.30 am	-	Bible Study I
10.15 am	-	Break
10.45 am	-	Plenary Session I : Dr. Dan Kaseje) (i) Background & Purpose of Consultation (ii) Overview on Christian Health & Medical Work
11.30 am	-	Plenary Session II i) Sharing some problems in the Christian Health Work ii) Case studies
1.00 pm	-	Lunch
2.15 pm	-	Group Discussions I i) Sharing Achievements & Problems ii) Summary of major problems: a) Problems of Christian Medical Work b) Problems of Christian Coordinating Agencies in Health
5.00 pm	-	Tea
5.15 pm	-	Departure for YMCA/YWCA Free evening Dinner in respective accommodation

4. Tuesday, 10 September 1991

7.30 am	-	Breakfast at YMCA/YWCA
8.15 am	-	Departure for CMAI
9.00 am	-	Devotions II
9.30 am	-	Bible Study II
10.15 am	-	Break
10.45 am	-	Plenary Session III Report on Group Discussion Summary of Concerns
11.45 am	-	Plenary Session IV Sharing Specific Solutions
1.00 pm	-	Lunch
2.15 pm	-	Groups Discussions II i) Mechanisms of cooperation, sharing and building up relationships ii) Strengthening Churches in the Ministry of Healing iii) What do we expect from CMC/WCC
5.00 pm	-	Tea
5.15 pm	-	Departure for YMCA/YWCA
7.45 pm	-	Dinner with Church leaders in Delhi

5. Wednesday, 11 September 1991

7.30 am	-	Breakfast at YMCA/YWCA
8.15 am	-	Departure for CMAI
9.00 am	-	Devotions III
9.30 am	-	Bible Study III
10.15 am	-	Break
10.45 am	-	Plenary Session V Future directions i) Report of Groups ii) Plenary Discussions
1.00 pm	-	Lunch
2.15 pm	-	Closing Session
4.00 pm	-	Tea with CMAI Staff
5.15 pm	-	Departure for YMCA/YWCA
7.30 pm	-	Dinner at Dr. Mukarji's residence

WHOLISTIC HEALING

- A PERSPECTIVE

Summary of Bible Studies by Rev. A.C. Oommen

I. EXPECTATION ABOUT HEALING :

The Gospel of St. Luke the physician does have an underlying language of health, healing and wholeness. The songs recorded as special material by him in Luke chapter 2(vs 12-14), chapter 1(vs 46-55) and chapter 2 (vs 28-35) stand testimony to this.

What these songs reveal may be referred to as the expectations about healing. This expectation consists of the new concept of healing, the content of healing and the cost of healing which the birth of Jesus brought into this broken world.

A) The new concept of healing:

The song of angels recorded in Luke 2 (12-14) proclaimed 'Glory to God in the highest, peace on earth good will towards all men'.

Let us consider the significance of some of the words contained in the above passage.

1) *Peace :* In the ancient community of Jews at the close of worship on every sabbath it was customary to use the words 'May the Lord, raise his countenance and give you peace'. Peace in this sense refers to Shalom which is not only an inner quietness or tranquility. Shalom is something that pervades all and creates harmony in nature and the whole creation.

   The Psalmist and the prophets spoke eloquently of a time in future when under the influence of Shalom farms will produce abundantly and the cattle will multiply ushering in healing and wholeness for all. A time when the swords shall be turned to ploughs and the lion and the lamb exist together. In other words a time when this broken world will be transformed into a healthy, wholistic world.

2) *On Earth:* The angels' song specifically refers to peace on earth. This reference expresses a vision of health which extends to the whole earth. It reveals that from the beginning of the incarnation the idea of a healthy world was conceived. This is why peace

on earth was proclaimed by the angels. It took time for the early church to recognise this. Peter and the other disciples were content to remain as a sect within the Judaistic faith. They were afraid to cut away from the apron strings of Judaism and plunge into the uncertain world. Then God raised a young man called Paul who addressed both the weak and small church and the outside world and spoke about the whole world proclaiming Jesus as Lord. He first spoke about all tongues confessing this truth and about all knees bending before the Lord. In another letter of his he referred to the subjugation of even all principalities and powers. In his epistle to Romans he goes even further, and states that the whole creation is stretching out its neck to see the restoration under Jesus, the restoration of a healed world under Jesus' rule. Thus the vision of healing proclaimed in the angels song is the vision of a whole and healthy creation. It is from this universal concept of healing that we proceed to the particular.

3) *Goodwill towards all:* In the original version of the angels' song there was not even a pause between the words peace on earth and the words goodwill towards all men. In otherwords peace on earth was equated with goodwill towards all men. The relationships within ourselves, with others, with the environment and with God is the basis of healing and wholeness.

B) Content of healing: Luke 1(46-55).

This passage is known as The Magnificate, the song of Mary. It perhaps contains more revolution in its ten verses than any other song of this type known to men.

These verses reveal the various types of revolution that need to take place in order to change existing order in this world and bring a new order which will ensure healing for the whole world.

Let us consider the various types of revolution that these verses speak about:

i) Personal revolution: V. 46-47:
Mary rejoices in the Lord, then proclaims that she has discovered meaning, significance and purpose to Life as the chosen vessel of the Lord. This is wholeness. It is a revolution at the personal level leading to wholeness.

ii) Social Revolution: V. 48:
She gladly reveals that from that day all generations would call her blessed. She speaks of all womanhood being called blessed.

Women were thus elevated from a simple family unit to the level of being blessed individuals. This verse speaks of the restoration of family and in consequence society by giving dignity and honour to women.

iii) Spiritual revolution: V. 49-50:
This speaks of God taking the initiative to restore all generations. Jesus broke Israel's pre-occupation with the law and led them towards a movement of healing. This a true spirituality.

iv) Political revolution : V. 51 & 52:
These verses proclaim a change in the world order. It speaks about the turning upside down of monarchs, vested interests and political structures.

v) Economic revolution: V.53:
A world where the hungry will be fed and the rich will be sent away empty handed is spoken about in this verse.

vi) Religious revolution: V. 54-55:
Renewal of God's convenant with man and a new beginning of a new Israel are announced by this verse.

Thus the magnificate reveals the various types of revolution that must take place to make this broken world become whole again. This song tells us that the incarnation of Jesus touches all aspects of human life and that nothing less can form the context of healing, health and wholeness.

C) The cost of healing : Luke 2 (29-35):

The song of Simeon : This song has two aspects.

1. The cost to Simeon for witnessing the deliverance; the vehicle of healing. Simeon and Anna are persons in every nation and every faith who have heard the call to dedicate themselves, trusting in the promise that God is faithful and that He will fulfill. It is in this sense of vocation and refusal to give up that they keep the light of hope burning inspite of darkness around. The cost they pay is in costly discipleship. This is wholeness.

2. The cost to Mary:
   Yes, she will be called blessed but, that also means a sword shall pierce here heart. Mary's life was one of pain, of rejection, of sacrifice. Wholeness does not mean always removal of pain or sickness, but, it means a sense of meaning and purposefulness in the midst of pain and suffering. Grace is costly. Healing means, all healers have got to take the challenge of the cross seriously. The scars of the wounds received on the cross should ever be retained on the body of Christ and then the world will recognise and fall and proclaim 'My Lord and My God' and that is wholeness for the world.

II. EXPERIENCE OF HEALING :

St. John 1(35-51)

Now let us see how some people experienced this wholistic healing by coming into contact with Jesus and examine how this healing took place in their lives.

We can look at three representative groups namely 1) The young (youth) 2) a professional and 3) a skeptical nationalist.

1. The two young men:

i) St. John gives a poignant account of his first meeting with Jesus. He and Andrew were together when St. John the Baptist pointed out Jesus to them saying "Behold the Lamb of God". Today we as healers are expected to point out the master healer to the sick world. As physicians, nurses and allied health professionals we are expected to do this. Pointing out the master healer is the initiation of the process of healing which God himself grants and completes.

ii) The two young people followed Jesus. He stopped so that they could catch up with him. When they came closer, he asked them the penetrating question "what seekest thou?". We must consider here whether it is worth seeking anything in this world ? We know that hundreds and thousands of noble men and women have sacrificed their lives over centuries seeking a world of peace. We stand on the ruins of their lives as aimless as ever, without a slogan to shout or a dream to live for. We forget that health and wholeness are the aim and purpose before us.

Unlike us the two young men John and Andrew knew what they were seeking so they answered that they wanted to be alone with

him. They wanted to be in his company to grasp the significance of his life and to participate in his mission to this world.

iii) John was very old (they say that he was almost 100 years old) when he wrote his gospel but in his naration of this incident he recalls the exact hour of his first meeting and dialogue with the Lord. It was 4.00 PM. He was able to recall that decisive hour because at that very hour his life had taken a new turn. Health and healing had happened to him. Andrew who had his priorities right also experienced healing at that very hour. He rushed home to his elder brother and shouted at him the word "Eureka" meaning that he had discovered the healer, the Messiah. He brought Simon to Jesus. The sign of true healing is therefore the transformation of the `healed' into `healers' who would look outward, seek the needy and bring healing and wholeness to them.

2. *The Professional:*

Simon was a tough, hard hearted fisherman. He was a professional in fishing; an expert in the field. He loved his work. He knew how to make quick decisions and strike a good bargain quickly. All these gifts he had were what the master could make excellent use of, but they had to be broken and remoulded and made whole. The Lord took one look at him, accepted him as he was but he also put his finger on the one point where Simon had to experience healing. He pointed out to the hardness in Simon which had to be broken and remoulded.

Simon was emotional, excitable and temperamental. Healing had to take place in him for Simon to be fruitful. However, it required a prolonged process spanning more than three and a half years. But when he was restored, healed, he stood head over shoulders above the rest and led his flock through the stormy days of the early church. What an experience of healing and wholeness!

3. *A skeptical nationalist (A politician):*

i) Nathaniel was a politician in the true mould, he was a cynic. When Philip who hailed from Nathaniel's constituency spoke to him about a person from their neighbouring town, Nathaniel's response was that no good thing could ever come out of Nazareth. He was convinced that there was no hope for the future. Therefore, he came to Jesus with very little expectation.

ii) Jesus immediately recognised him as a true Israelite; a true nationalist. As one who fights with God on behalf of his nation and as one who holds the promises of God on the one hand and the aspiration and hopes of his people in the other. Nathaniel was one who was struggling to bring together his people who were frustrated by the bitter realities of every day life.

He was doing what Jacob did on the banks of river Yabok where Jacob earned the title Israel. Jacob was given one day the promise of God that the whole world would be blessed by God in his children and the next day he had to wrestle with God to bring those promises down to earth and to raise the realities of earth upto heaven. The whole history of Israel reflects this. They had to learn to live in tension.

Jesus recognised the tension in Nathaniel who was struggling with this at the hour of prayer and reminded him of the same.

iii) The theophany for Nathaniel "Thou art the Messiah" was the realisation that the struggle had now become personified. The sacred and secular are embodied in Jesus. Nathaniel realised that his urge and tension were being swallowed up in the tension and passion that the Lord Himself was undertaking. Not only him but of hundreds before and after. This was gathered together in the cry 'My Lord, You are the King of Israel.' Nathaniel needed to say this for hope and health to be restored by the master in him.

iv) The Lord leads Nathaniel to see the essence of this healing, restoring process. Ladders and bridges are going to be set up in his person. Relationships are to be restored and healing of the whole universe is assured. In Him, there is no place for cynicism.

III. THE EXPRESSION OF HEALING OR THE EXAMPLE OF HEALING :

Mathew : 25

Now let us consider how this healing experienced by a few people is expressed or exemplified in this world.

The ultimate is reached from the grassroot. Healing has to take place and wholeness must take root between the time of Jesus first coming and His second coming. This is the period in which the community of true disciples; the community of healed are called to act.

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Mathew 25 has some lessons to give us about this. The disciples were trying to push Jesus towards Jerusalem so that He could be in a city situation and gain popularity and if possible eventually become king. This is reflected in their concern for position. They wanted to know who would occupy the seat on Jesus' right hand side and left hand side when he became King.

Jesus was concerned about what they as a community of disciples and healers would be doing between the time of his first coming and his second coming. For the healing experience had to be exemplified in this period, and healing cannot be experienced except in the community itself.

i) The parable of ten virgins:

The inner life of the community "the light" should continue to burn i.e. the vision of healing brought in by Jesus should continue to be kept alive in the community.

If a vision is not kept alive it would eventually result in death and decay. Sociologists point out that there are four stages in this.

a) A vision is found.
b) Conflict between structure and vision.
   Consequent failure to maintain balance between structure and vision.
c) Structure overtakes vision.
d) Death and decay.

Therefore it is imperative that the vision is kept alive by the community of disciples. A community of healed people should keep the fire burning; a group which continuously and constantly waits on the Lord for the second vision.

Five virgins let the vision die out. Therefore, the central question of this parable is 'Is the fire burning?

ii) The parable of the Talents : V. 14-32:

Talent means (Gr. Talent) Ministry - Mission:
Jesus handed over his mission to his disciples and the structure to which he handed over this mission was a community of a few fishermen. They had to carry out this mission. This reflects God's faith in men and these few weak men were God's faithful men.

The Lord speaks of the master's return and states that the master 'reckoneth'. This word means that the master audited the account.

Mathew an accountant by profession uses this word twice in his writing. It reveals that all accounts related to the carrying out and the accomplishment of the mission would be audited after a long time.

The first servant was worldly wise. He buried the talent. He was unwilling to take the risk in faith.

'Sorren Kirkegard' the philosopher said 'I made the leap of faith, he caught hold of me'. This is true of the whole christian faith. It means plunging into the unknown having faith that God is there to hold and support us. Faith is that period of vaccum of uncertainty where He supports us; faith is the assurance that the Lord will never let go. Faith is the certainty that the Lord is victorious. Faith is the absolute certainty that the young student has while writing his exams that he has already secured a first class.

The parable of the Goats and Sheep. V. 3

The theme again is community. The intention was not to make a distinction between goats and sheep but it was to show the nature of the life of the little community, the body of Christ, the church as against that of the community of nations who ill treated this body of Christ.

The challenge posed here is the question where and how should the Church be found ? The answer is that the church should be found a) hungry and thirsty because it feeds and quenches the thirst of those who need to be fed and given to drink b) The church's should be found as strangers because we belong not to this earth but to heaven. This strangness is essential to maintain relevance c) The church should be found naked because we clothe others d) It should be found sick because we are taking upon ourselves the sickness of others e) It should be in prison because it sets others free.

Our strength as the church is the strength of weakness; the strength of empowering others. Therefore, i) we must maintain the vision ii) we must venture in to the unknown with faith in God iii) in this process we remain weak but strengthen others.

The challenge today is to see resurrection "in" the cross; to see healing in sickness. This is the expression of true wholistic healing. Our responsibility is to form such communities of true healers which find strength in weakness. We have to share above all the knowledge and assurance that Jesus Christ is the victor and that he has no other alternative for the fulfilment of this mission but us.

We may summarise thus :

a) Faith is a leap into the light and not into darkness.
b) Healing is not possible without pain.
c) Salvation, health, healing and wholeness are free gifts from God as Jesus has already paid for these gifts.
d) All healers must bear the wound and scars of the cross inorder to bring healing to others.

Further more we should realise that (i) the concept of healing goes beyond individual well being to well being of the whole world for the glory of God. (ii) content of healing refers to the creation of a new order. (iii) cost of healing indicates that the healing church must pay the price once again on the cross.

When the world once again sees the wounds of the cross on the healers and in the church it will accept healing and proclaim "My Lord ! My God".

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PROBLEMS OF CHRISITAN MEDICAL MISSION IN INDIA

India is a vast sub continent and the church in India has been recognised in playing a major role in caring for sick and suffering for the past hundred years and more in this country. The population in India has increased by leaps and bounds during the past two decades. The recent census has indicated that we are nearly eight hundred and fifty million people living on limited available land area of 3.3 milllon square kms. 72% of our people are residing in 580,000 villages spread over 446 districts. Hindus form 83% of the people where as Muslims are 11% and Christians are about 2.6%. Though Christians figure in India as minority yet they form over 22 million people.

Demographers have analysed population growth in terms of four factors. 1) Fertility 2) Mortality 3) Immigration 4) Emigration. But in the Indian situation the last two factors are least important. While the death rate could decline from 41 in 1891 to 12 in 1991 (in hundred years), the birth rate has been still very high at 35 compared to 50 in 1891. The ambitious Family Planning Programmes launched by our Government at the cost of other Health Programmes have invariably failed to achieve the set targeting of reducing the birth rate. Further it has emphasised a shift towards the concern for Family Welfare which includes programmes such as promoting female literacy and creating employment opportunities for them, raising the status of women in society, raising the mean age at marriage, spacing of children, lowering the maternal mortality rate and improving the health and survival of children. Health is no more a medical matter but rather an amalgamation of several social, cultural, psychological and economic factors.

The Imprint, a monthly publication in India reported that 200 million people in India suffer from various degrees of malnutrition, 400 children die every hour from preventable diseases, 1.5 million babies succumb to diarrhoea, 40,000 go blind annually, 7 mllllon are born under weight and what is next? 500,000 primary schools have about 70 milllon students, about 40% of them are girls and of these 288,000 schools don't have drinking water, 188,000 schools don't have black boards 150,000 children have only one teacher for all classes of about 200 children and 168,000 children have no benches or desks.

Further 90,000 Indian villages do not have access to safe drinking and adequate water within 1.5 k.m. distance. Even the basic requirements such as proper sanitation, the country has far to go - out of total of 3245 towns in the country a mere 217 have total sewerage and sanitation facility. And ofcourse the facilities are almost non existant in rural areas. There are 10 million T.B. patients in the country and an additional five hundred thousand fresh cases are added every year. Anti T.B. drugs make up a paltry 1.4% of the Indian drug market. The press reports that if India has to provide her burgeoning population with its basic needs she needs to set up one hundred and seventy thousand new schools, employ 33,000 extra teachers, construct 2.5 million additional houses and manufacture 300 million more meters of cloth besides coming up with an additional 40,000 jobs to cope with the increasing number of its hungry, deprived, multitude.

To meet the challenges in health care in this country the Government of India has gone ahead in a big way in establishing basic infrastructure in rural areas such as 20,531 Primary Health Centres 130,000 sub centres, deploying various kinds of health workers at grass root level. The current situation is that 80% of the doctors are working in the urban areas where only 28% of the population live. The doctor and nurse ratio has been out of proportion, we have more doctors and less nurses. The number of Medical Colleges has risen from 30 in 1947 to 126 today. The post independence period in India has witnessed this spectacular growth of an institutionalised curative health delivery system.

The Chrisitian Medical Association of India is the official medical wing of the National Council of Churches. It reviewed Christian Health Services rendered through about 350 Mission Hospitals in this country some time during the year 1985 and 1986. It was tragic to note that when there were about 700 Mission Hospitals and Christian Health Centres at the time of Independance in 1947 we have today only about half of them. A survey conducted about 15 years ago had revealed to us that 18% of all beds in India are in Mission Hospitals, and 23% of all out patients in our country pass through Mission Hospitals. Yet many of the Institutions are on the verge of closing or may not continue for long. The study group found out that the problems faced in Christian Medical Mission are :

1) The lack of understanding in the Church about the Healing Ministry of Christ.

2) The lack of Mission to serve the people of this country.

Most specifically it has come out that we need people with competency, commitment and dedication. It is surprising to note how in a country like ours we lack Christian professional leadership when there are 22 million Christians in India today and inspite of having prestigious training centers for doctors and nurses affiliated to CMAI.

The other problems seen in this process have been the lack of stewardship and proper management of hospitals and health centres. Ofcourse lack of funds has certainly played a role in this.

The Christian Medical Association of India which started 65 years ago has a mandate to help the Church in its Healing Ministry. CMAI attempts to serve the Church as it tries to fulfill the challenge of meeting the unlimited demands of 850 million people in the face of uncertain political situation and disturbing socio-economic problems the country is facing today. The CMAI works with and for people so that there may be health for all. Inspite of Government's duty to provide health services to all in this land, the CMAI recognises that Voluntary Agencies have a crucial role to play in this process to bring health to the people. At the same time CMAI is also concerned with social justice issues in the provision and distribution of health services, and believes that people themselves have an important part to play in their own health. CMAI wants a better life for the poor and weaker sections of our country. So we are involved in educating, motivating and sensitising the church, christians and health professionals to be involved in these practical issues of health and wholeness in our society.

Most of our member Institutions have been recognised during the past several years for their innovative programmes besides the compassionate, loving and tender care and are well known for their sense of dedication and service. So CMAI belives that these Institutions and Church today should continue to display quality care with competance, compassion and commitment yet relevant to the Indian situation. As the Indian Christian Medical Mission has pioneered in areas by providing health to the poor and needy in the past, there is still a tremendous scope and opportunity for Christian Medical Mission in India to get involved in bringing health, healing and wholeness in newer horizons in womens issues, AIDS, rehabilitation of physically and mentally handicaped etc.

With this information I would like to present a brief report on the CMAI's involvement in helping the Church in the healing ministry.

1) Leadership Development

It prepares and challenges Chrisitan health professionals to a vocation in serving the Lord and making health a reality for people in our country. The people with competance and commitment need to be identified, supported, nurtured and encouraged in their respective services. So human resource developemnt of staff, students and the community itself becomes important.

2) The CMAI is committed to Community Health

It accepts primary health care, appropriate referal services, training centres and hospitals in its commitments to build up a healthy community. So we create awareness, understanding and support for the principles and practice of Community Health with special emphasis on community based services .

3) Understanding the Healing Ministry

It is our desire to rediscover and realise the lost vision in our congregations that would lead us in realizing our Lord's commission to teach, preach and heal. Health becomes a social justice issue and churches, congregations and christian health professionals are educated to be involved in building a healthy society where justice, dignity, equality and health abound.

4) Revitalizlng Hospitals and Health Institutions

CMAI helps these Institutions to regain their vision and purpose becoming alive to the changing environment and working conditions. Our Mission Hospitals and Health Centers need to be more effectively and efficiently managed and to become resources for education and service in the country. CMAI helps our institutions in these directions.

5) Building up CMAI

As a christian fellowship we are committed to making health a reality in India. So CMAI needs to build up its membership, infrastructure, staff and resources for strengthening its services. It can give direction and leadership in christian medical work in India. Manpower development and financial stability are crucial areas of concern for CMAI itself.

6) CMAI a giving community

CMAI and church should seek out ways to extend their services to other countries and communities who may have greater needs than ours. This concept of sharing our resources and expertise will allow

us to grow and participate in international christian medical fellowship and solidarity.

In practice we organise conferences, consultations and retreats to promote the fellowship and spiritual growth among christian health professionals who are nurses, doctors, hospital administrators, allied healh professionals and chaplains drawn from all spheres of life and work in India.

We publish and distribute educational material for promoting the knowledge and skills of all categories of health professionals. We also run formal training programmes for nurses, doctors, allied healh professionals, hospital administrators and chaplains.

We work with other voluntary agencies like the Catholic Hospital Association of India and Voluntary Health Association of India and are in the process of building up links with other voluntary agencies in India and with Government as well. This enables us to strenghthen our work by working together as a team and as partners in realising health for all especially in areas of education, publications and celebration of Healing Ministry Sunday.

The CMAI has been able to provide guidance and play a consultancy role to our institutions whenever such services are asked for.

We have been involved in providing technical know how and limited financial support to help our church and church related Instituitions to start and run programmes relevant and appropriate to the needs of the country today especially addressing to poor, needy, marginalized, women and children.

All these activities may be means to an end and we may be launching into new areas getting new directions and new vision according to the changing scene in our land. But what we intend in CMAI today is to prepare people who are socially relevant, professionally competant and spiritually alive. Through them we equip the church to serve our country. We want to improve the quality of life - abundant life - for all the people of India.

DR.SUKANT SINGH
Assoc. Gen. Secretary
CMAI

GENERAL INFORMATION

CMAI began in 1905 as the Medical Missionary Association of India. In 1926 it was renamed the Christian Medical Association of India. Today CMAI is a charitable, non profit, christian educational society working for the promotion and the maintenance of health. It acts as the official health agency of the National Council of Churches in India (NCCI) and thus is related to a wide network of Protestant and Orthodox Churches. At present member institutes are related to the following Churches: Assemblies of God, Baptists, Church of North India, Church of South India, Lutherans, Mar Thoma, Mennonite, Methodist, Nazarene, Presbyterian, Salvation Army, Seventh Day Adventists, Malankara Jacobite Syrian Orthodox, Orthodox Syrian etc.

CMAI now has about 300 institutions (hospitals, health centres, community programmes etc) and approximately 3000 individual members. It is registered in Nagpur with its headquarters in New Delhi. There is a South Office in Bangalore where the area office, Boards of nursing education and some regional activities are coordinated. Its national assembly meets at a Biennial Conference to review policies and programmes, set out priorities and to have elections. In the alternate year sectional conferences for each health professional group takes place. Regional, grass root and local activities are organised by CMAI in the 12 regions throughout India.

BASIS:

"Jesus called the twelve disciples together and gave them power and authority to drive out all demons and cure diseases. Then he sent them out to preach the Kingdom of God and to heal the sick". (Luke 9:1-2)

GOAL:

To serve the Church in India so as to equip, assist and encourage it in its ministry of healing, health and wholeness.

OBJECTIVES:

Prevention and relief of human suffering irrespective of caste, creed, community, religion and economic status.
Promotion of knowledge of the factors governing health.
Coordination of activities for training doctors, nurses, paramedicals and others involved in the ministry of healing.
Implementation of schemes for comprehensive health care, family planning and community welfare.

FUNCTIONS:

CMAI is available to the churches and members in India to provide technical, administrative and other support so as to build up their ministry and capacity to serve our people.

Fellowship: Encouraging spiritual, professional and social fellowship for members through retreats, conferences, workshops and special programmes.

Education & Training: Supporting health professional training, formal and non formal programmes, education of the public in health promotion and maintenance and continuing education for members.

Assistance & Consultancy: Facilitating technical, financial and programme assistance through specialised departments and staff.

Helping Churches: Seeks to help the churches rediscover and redefine the mission of health, healing and wholeness.

Advocacy: Promoting policies and actions that help influence others on issues of social justice, total well being and the building of healthy communities.

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